Wayland Medical Associates

Richard J. Ruggieri, MD Geoffrey H. Berg, MD Abbey Barkley, MSN, FNP-C

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ DOB: _____

Address: _____ Phone _____

I authorize Wayland Medical Associates to:

Release Medical Records To: _____

_____

_____

Fax # _____

Obtain Medical Records from: _____

_____

_____

Fax # _____

__ Immunizatoins	___ Lab/Imaging Reports	___ Mental Health Information
__ Entire Medical Record	___ Progress Reports	___ HIV-related Information

Reason for release of information

___ Coordination of Care	___ Transfer of Care	___ Legal	___ Insurance

I understand that my records are confidential and cannot be disclosed without my written consent, except when otherwise permited by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specific information to be released may include but is not limited to history, diagnosis and/or treatment for drug and alcohol abuse, mental illness, communicable disease including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that the action has been taken in reliance upon the authorization. The authorization will expire six (6) months from thte date of my signature, unless I revoke the authorization prior to that time.

_____ _____ _____

Signature of patient or legal representative Printed name (if not patient) Date

160 Wayland Avenue
Providence, RI 02906
(401) 521-1221, Fax: (401) 454-4189